

Profile | Biofourmis Care

- Comprehensive virtual care platform that enables remote care management across the entire care continuum: acute, post-acute, and chronic care in the home
- Virtual specialty care clinics with a focus on longitudinal disease management by leveraging monitoring technologies + data science + clinical care services
- Clinical care teams include health navigators, licensed clinicians including physicians, nurses, and advanced practice providers
- Initial priority clinical conditions for virtual care including heart failure, hypertension, diabetes, lipid disorders, atrial fibrillation

Mike's Story

Mike is a polychronic, older adult patient living at home. He is being treated for diabetes, heart failure, and hypertension by a primary care physician (PCP) in an Accountable Care Organization (ACO) but, lately, his conditions have limited his mobility and his health is declining. He frequently calls Emergency Medical Services (EMS) and is transported to the local emergency department when his symptoms worsen.

**Intake and Onboarding**

At a recent office visit, Joe's PCP considers referring him to specialists to get his conditions under control, but long wait times and cost-sharing are an issue. Instead, the PCP opts to refer him to a new program available through the ACO's partnership with Biofourmis Care. A health navigator from Biofourmis' clinical care team reaches out to Joe to enroll him in the program. Biofourmis ships a pre-packaged kit to Joe which includes: 1) Connected devices that collect and transmit physiological signals to the Biofourmis platform, and 2) instructions for downloading a patient companion smartphone app that enables and empowers Joe to engage with his care plan and stay connected to the Biofourmis care team by telephone, chat, or video, 24/7. The navigator serves as his main point of contact, guiding him through technical troubleshooting and answering clinical questions. This relationship becomes instrumental for Joe in helping him make lifestyle modifications and overcome obstacles to adherence to his care plan.

**Longitudinal Co-Management**

Once in the program, the Biofourmis clinical team can adjust Joe's personalized care plan based on his conditions and severity, optimizing prescriptions according to guideline-recommended medical therapy. Throughout the process, Biofourmis' care team can prescribe medications, order relevant labs, and even conduct prior authorization calls. When concerns arise, Joe trusts the navigator to triage and escalate issues to the appropriate Biofourmis clinician, a medical specialist who will provide a higher level of clinical expertise as needed. Additionally, trends and alerts generated by FDA-cleared automated monitoring algorithms enable the remote care team to predict and intervene when Joe needs a change in his care plan or medication. This proactive approach keeps him healthier and prevents the need for urgent and emergency care. Critical notifications alerts are always escalated, with notifications sent directly to Joe's PCP physician, and the electronic health record (EHR) updated accordingly. With the additional layer of chronic disease support provided by Biofourmis, Joe's PCP is confident that she can continue to manage his care. He continues receiving guideline-directed medical therapies (GDMT) for his multiple conditions, without additional cost and delay of outside specialty care.

“These virtual care teams partner with the patient’s pre-existing, on-the-ground primary and specialty care providers. We’re an extension of their primary care team and we’re here to augment what they’re doing as a support team.”

- Maulik Majmudar, Biofourmis CMO

TAKEAWAYS FOR EFFECTIVE CARE TRANSITIONS

Partnering to Foster Awareness and Trust



Effective partnerships extend and augment rather than compete with the capabilities of existing in-person care teams.

Partnerships should yield clinical and financial returns on investment for providers, payors, and value-based organizations such as ACOs. For example, timely, efficient, and safe optimization of evidence-based therapies by V1C partners supports optimal outcomes and reduction in the total cost of care by reducing emergency department visits and hospital admissions.



Clinical Integration

Shared clinical care protocols and agreed-upon care triage and escalation workflows between virtual and bricks-and-mortar providers improve patient outcomes and foster trust between clinicians.



Bi-Directional Communication

Co-managing clinical partners should receive timely updates to patient health records from V1C partners, including relevant and actionable event alerts through automated processes and patient and/or population level dashboards.



Incentive Alignment

Shared savings and other risk-sharing and performance-based contracts align incentives for high-value care.



Visit the [V1C Care Transitions Toolkit](#) or view additional [V1C Care Transitions Case Studies](#).